

**Richard L. Benson, Ph.D., P.A.**  
Licensed Psychologist  
7111 West 151<sup>st</sup> Street, Suite 286  
Overland Park, KS 66223  
Phone 913/596-8808 Fax 913/897-7487  
[www.bensonpsyc.com](http://www.bensonpsyc.com)

**ADULT NEW PATIENT FORM**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Gender:** Female Male

**Address:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Position?** \_\_\_\_\_ **How long?** \_\_\_\_\_

**Spouse/significant other's Name** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Primary Care Physician's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**Medical Issues:**

**Currently being treated for:** \_\_\_\_\_

**In past treated for:** \_\_\_\_\_

**Medications:**

**Name:** \_\_\_\_\_ **Dosage/Frequency** \_\_\_\_\_ **By** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Dosage/Frequency** \_\_\_\_\_ **By** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Dosage/Frequency** \_\_\_\_\_ **By** \_\_\_\_\_

**Purpose for seeing Dr.Benson:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

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**Signature/Acceptance Page**

**Please initial and date all applicable statements below:**

**Initial**

**Date**

I agree that all charges incurred by me or my dependent(s) are my responsibility to pay (unless some other written authorization has been obtained).

\_\_\_\_\_

\_\_\_\_\_

I understand that 24 hours notice (1 business day: Friday if appointment is on a Monday, or the business day prior to a holiday if appointment is the day following a holiday) must be given if an appointment must be cancelled to avoid being charged the full fee for the appointment.

\_\_\_\_\_

\_\_\_\_\_

I assign payment of insurance benefits to this office. I understand that I am completely responsible for any penalties, denials, or disputes of non-payment for services by my insurance company.

\_\_\_\_\_

\_\_\_\_\_

I authorize the release of any medical or other information necessary in order to process my insurance claims.

\_\_\_\_\_

\_\_\_\_\_

**I have reviewed all the information on the New Patient Form and, to the best of my knowledge, it is correct and complete. I acknowledge that I have been given access to Dr. Benson's Psychotherapist-Patient Services Agreement and the HIPAA Notice Form (on his website at [www.bensonpsyc.com](http://www.bensonpsyc.com)) and agree to abide by their terms.**

\_\_\_\_\_  
Printed Name of Patient (Parent if Patient is a Minor)

\_\_\_\_\_  
Signature of Patient (Parent if Patient is a Minor)

\_\_\_\_\_  
Date